AMENDATORY SECTION (Amending WSR 00-06-027, filed 2/24/00, effective 3/26/00)

WAC 296-23A-0200 How does the department pay for hospital inpatient services? The department will pay for hospital inpatient services according to the following table:

Hospital Type or Location	*Do Diagnosis Related Group (DRG) payment methods apply?*	*Do per diem payment methods apply?*	*Do percent of allowed charges (POAC) payment methods apply to hospital inpatient services?*
Children's Hospitals	No	No	Yes, paid 100% of allowed charges
Chronic Pain Management Program	Exempt, paid per department agreement.	Exempt, paid per department agreement.	Exempt, paid per department agreement.
Health Maintenance Organizations	No	No	Yes, paid 100% of allowed charges
Military	No	No	Yes, paid 100% of allowed charges
Veterans Administration	No	No	Yes, paid 100% of allowed charges
State psychiatric facility	No	No	Yes, paid 100% of allowed charges
((~~Washington rural (Peer Group A)~~	~~No~~	~~Yes, statewide per diem rates apply for five DRG categories: Chemical dependency, psychiatric, rehabilitation, medical, and surgical DRGs~~	~~No~~))
All other Washington hospitals	Yes	Yes, statewide average per diem rates apply for designated categories: Chemical dependency, psychiatric, rehabilitation, low volume medical, and low volume surgical DRGs	Yes, applies to low cost outlier payments and high cost outlier payments above the high cost outlier threshold

AMENDATORY SECTION (Amending WSR 01-24-045, filed 11/29/01, effective 1/1/02)

WAC 296-23A-0220 How does the department pay for hospital outpatient services? The department will pay for hospital outpatient services according to the following table:

Hospital Type or Service Location	*Does the Ambulatory Payment Classification System apply?*	*Do percent of allowed charges (POAC) payment methods apply?*	*Do the department's Medical Aid Rules and Fee Schedules apply to hospital outpatient radiology, laboratory, pathology, occupational therapy, and physical therapy services?*
Children's hospitals	No	Yes, paid 100% of allowed charges	Yes
Chronic Pain Management Program	No	Exempt, paid per department agreement	Exempt, paid per department agreement
Health Maintenance Organizations	Yes, paid statewide average per APC rate	Yes, applies to certain hospital outpatient services excluded from OPPS except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes
Military	No	Yes, paid 100% of allowed charges	No, paid 100% of allowed charges
Veterans Administration	No	Yes, paid 100% of allowed charges	No, paid 100% of allowed charges
State psychiatric facility	No	Yes, paid 100% of allowed charges	Yes
Other psychiatric hospitals	No	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes
Rehabilitation hospitals	No	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes
Cancer hospitals	No	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes

((~~Washington rural (Peer Group 1)~~	~~No~~	~~Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy~~	~~Yes~~))
Critical access hospitals	No	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes
All other Washington hospitals	Yes	Yes, applies to certain hospital outpatient services excluded from OPPS except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes

Hospitals are reimbursed only for the technical component of rates listed in the fee schedules, for outpatient radiology, pathology and laboratory services.

See chapter 296-23 WAC for rules on radiology, pathology, laboratory, physical therapy, occupational therapy, and work hardening services.

See WAC 296-23A-700 for rules on prospective payment system for hospital outpatient services.

See WAC 296-20-132 and 296-20-135 for information on the conversion factor used for certain hospital outpatient services.

AMENDATORY SECTION (Amending WSR 01-24-045, filed 11/29/01, effective 1/1/02)

WAC 296-23A-0221 How does the self-insurer pay for hospital outpatient services? The self-insurer will pay for hospital outpatient services according to the following table:

Hospital Type or Service Location	*Do percent of allowed charges (POAC) payment methods apply?*	*Do the department's Medical Aid Rules and Fee Schedules apply to hospital outpatient radiology, laboratory, pathology, occupational therapy, and physical therapy services?*
Children's hospitals	Yes, paid 100% of allowed charges	Yes
Chronic Pain Management Program	Not Applicable	Not Applicable
Health Maintenance Organizations	Yes, paid 100% of allowed charges	Yes
Military	Yes, paid 100% of allowed charges	No, paid 100% of allowed charges

Veterans Administration	Yes, paid 100% of allowed charges	No, paid 100% of allowed charges
State psychiatric facility	Yes, paid 100% of allowed charges	Yes
Other psychiatric hospitals	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes
Rehabilitation hospitals	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes
Cancer hospitals	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes
((~~Washington rural (Peer Group 1)~~	~~Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy~~	~~Yes~~))
All other Washington hospitals	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes

Hospitals are reimbursed only for the technical component of rates listed in the fee schedules, for outpatient radiology, pathology and laboratory services.

See chapter 296-23 WAC for rules on radiology, pathology, laboratory, physical therapy, occupational therapy, and work hardening services.

See WAC 296-23A-700 for rules on the prospective payment system for hospital outpatient services.

See WAC 296-20-132 and 296-20-135 for information on the conversion factor used for certain hospital outpatient services.

AMENDATORY SECTION (Amending WSR 00-06-027, filed 2/24/00, effective 3/26/00)

WAC 296-23A-0240 How does the department define and pay a new hospital? New hospitals are those open for less than one year prior to the implementation of the department's most recent hospital payment rates. The department will pay new hospitals according to the following table:

Hospital Type or Location	*What Diagnosis Related Group (DRG) base price applies?*	*What Per Diem Payment Rates Apply?*	*What percent of allowed charges (POAC) factor applies?*

Military, Veterans Administration, State Psychiatric, Health Maintenance Organization, Children's,	Exempt	Exempt	Paid 100% of allowed charges
Chronic Pain Management Program	Exempt, paid per department agreement	Exempt, paid per department agreement	Exempt, Paid per department agreement
((~~Washington Rural Hospital (Peer Group A)~~	~~Exempt~~	~~Washington statewide average per diem rates~~	~~Washington statewide average POAC~~))
Other Washington Hospital	Weighted median case-mix adjusted average cost per case for Washington DRG hospitals, except major teaching hospitals	Washington statewide average per diem rates	Washington statewide average POAC

A new hospital will be paid using its hospital-specific POAC within three years of receiving a provider account number(s) from the department.

AMENDATORY SECTION (Amending WSR 97-06-066, filed 2/28/97, effective 4/1/97)

WAC 296-23A-0480 Which hospitals does the department exclude from diagnosis-related-group (DRG) payments? The following hospitals are excluded from DRG payments:

- Military, Veterans Administration, state psychiatric facilities, health maintenance organizations (HMO), and children's hospitals will be paid their allowed charges.
- Department-approved chronic pain management programs will be paid according to department agreement or contract.
- ((~~Peer Group A hospitals, as defined by the department of health, will be paid using per diem rates.~~))
- Hospitals located outside of Washington will be paid a percent of allowed charges (POAC).
- Other hospitals, as determined by the department, may be excluded from DRG reimbursement rates due to concerns about access, case volume or other considerations. These facilities will be paid using the applicable POAC factor and per diem rates.

AMENDATORY SECTION (Amending WSR 03-21-069, filed 10/14/03, effective 12/1/03)

WAC 296-23A-0710 Definitions. "Alternate outpatient payment." A payment for proper and necessary services calculated using a method other than the APC method, such as the outpatient hospital rate or fee schedule.

"Ambulatory payment classification (APC) bill." An outpatient bill for hospital services that are grouped and paid using APCs.

"Ambulatory payment classification (APC) weight." The relative value assigned to each APC by CMS. For information on calculating the APC weights, please see 42 CFR, Chapter IV, Part 419, et al. Medicare Program; Prospective Payment System for Hospital Outpatient Services.

"Ambulatory payment classification (APC)." A grouping for outpatient visits which are similar both clinically and in the resources used.

"Ambulatory surgery centers (ASCs)." Ambulatory surgery centers as defined by the department. ASCs are excluded from the APC payment system.

"Blended rate." The dollar amount used to determine APC payments.

"Bundling." Including the costs of supplies and certain other items with the costs of APCs. Bundled services will not be paid separately.

"Cancer hospitals." Freestanding hospitals specializing in the treatment of individuals who have a neoplasm diagnosis.

"Children's hospitals." Freestanding hospitals specializing in the treatment of individuals less than fourteen years of age.

"CMS." Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration (HCFA).

"Correct coding initiative." A process to encourage hospitals to code the most appropriate diagnosis and procedure for the services rendered.

"Critical access hospitals." Critical access hospitals as defined by the department of health.

"Current procedural terminology (CPT)." A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, interventions performed by physicians; the American Medical Association (AMA) publishes it annually.

"Discount factor." The percentage applied to additional

significant procedures when a claim has multiple significant procedures or when the same procedure is performed multiple times.

"Exempt services." Services and hospitals that have been identified by CMS and/or L&I as exempt from the APC-based payment system.

"Health care common procedure coding system (HCPCS)." Medicare's procedure coding system, which consists of Level 1 CPT Codes, Level 2 National Codes, and Level 3 Local Codes.

"Incidental services." Proper and necessary services that are integral to the delivery of the significant procedure or medical visit and are not separately reimbursable.

"Inpatient only procedures." Certain procedures designated by CMS as being of sufficient resource intensity that an inpatient setting is always required.

"Modifier." A two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. Modifiers add clarification to procedures and can affect payment. Modifiers are listed in the current CPT and HCPCS manuals.

"Non-APC services." Services specifically excluded by CMS or by L&I from APC payment.

"Out-of-state hospitals." Any hospital not physically located within the state of Washington.

"Outpatient code editor." A prepayment analysis program designed to exclude certain diagnostic and procedure codes from being classified within the APC payment system.

"Outpatient prospective payment system (OPPS)." A payment system that groups hospital outpatient visits into APCs and multiplies the relative weight factor by the OPPS conversion rate to determine the appropriate payment.

"Outpatient services." Proper and necessary health care services and treatment ordinarily furnished by a hospital in which the injured worker is not admitted as an inpatient.

"Outpatient." A patient who receives proper and necessary health care services or supplies in a hospital-type setting but is not admitted as an inpatient.

"Partial hospitalization." Mental health services provided in an inpatient setting without the traditional inpatient overnight stay.

"Pediatric services." Proper and necessary health care services and treatment ordinarily furnished by a hospital in which the injured worker is under the age of fourteen.

((~~**"Peer group."** Categories of hospitals adopted by the department of health for rate setting purposes. The categories are:~~

~~- Group 1 - Usually rural hospitals.~~

~~- Group 2 - Usually urban hospitals without a medical education program.~~

~~- Group 3 - Hospitals with a medical education program.~~))

"Psychiatric hospitals." Freestanding hospitals specializing in the treatment of individuals with a mental health disease.

"Rehabilitation hospitals." Freestanding hospitals specializing in the treatment of individuals in need of rehabilitative services.

"Related encounters or related services." Multiple encounters which are:

- Provided within the same window of service; and
- By the same provider (hospital).

"Single visit." A single visit includes all related services that are combined for reimbursement when they occur with the same hospital during the window of service.

"Special programs." Programs specifically designated by the department.

"Transitional pass-through." Certain drugs, devices and biologicals, as identified by CMS that are entitled to a specified payment until CMS assigns and reimburses them under their own APC.

"Window of service." A single date of service. All services associated with the visit for that date constitute a single visit, even when those services are provided on different days.

AMENDATORY SECTION (Amending WSR 01-24-045, filed 11/29/01, effective 1/1/02)

WAC 296-23A-0750 What exclusions and exceptions apply to ambulatory-payment-classification (APC) payments for hospital services? (1) ((~~Peer Group 1 (rural) hospitals as identified by the Washington state department of health (DOH).~~

~~(2)~~)) Critical access hospitals as identified by the Washington state department of health (DOH).

((~~(3)~~)) (2) All out-of-state hospitals.

((~~(4)~~)) (3) Military/veterans hospitals.

((~~(5)~~)) (4) Psychiatric hospitals.

((~~(6)~~)) (5) Rehabilitation hospitals.

((~~(7)~~)) (6) Cancer hospitals.

((~~(8)~~)) (7) Children's hospitals.

((~~(9)~~)) (8) Ambulatory surgery centers.

((~~(10)~~)) (9) Any outpatient service or special program identified by the department or by CMS as being a non-APC service.

((~~(11)~~)) (10) Any inpatient-only procedures as identified

by CMS.

((~~(12)~~)) (11) Any APCs identified by the department as a non-APC service.